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Office of Administrative Law Judges
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Issue Date: 20 December 2004

Case No: 2001-BLA-0336

BRB No.: 03-0434 BLA

In the Matter of:

SUSAN DUGGER, Widow of
CHESLEY DUGGER,
Claimant

v.

OLD BEN COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Before: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER ON REMAND - DENIAL OF BENEFITS

On February 28, 2003, a Decision and Order denying benefits was issued by the undersigned Administrative Law Judge. The Claimant appealed. In a split Decision by the Board, the Decision was affirmed in part, vacated in part, and the case was remanded by Decision and Order of the Benefits Review Board, BRB No. 03-0434 BLA, issued on April 29, 2004. The record was received in the Office of Administrative Law Judges on July 15, 2004.

By Order dated July 27, 2004, the record was held open until August 23, 2004, for submission of briefs. On August 13, 2004, the Claimant requested additional time to file a brief. The Claimant's request was granted by Order dated August 19, 2004, setting a new briefing deadline of August 31, 2004. Both parties have filed briefs.

In its Decision and Order, the Board affirmed my findings that x-ray evidence supported the existence of pneumoconiosis under § 718.202(a)(1), that autopsy evidence supported a finding

of pneumoconiosis under § 718.202(a)(2), and that the Miner's pneumoconiosis arose out of coal mine employment under § 718.203(b). *Dugger v. Old Ben Coal Co.*, BRB No. 03-0434 BLA at 2 (April 29, 2004).

The Board held that the July 18, 1999, x-ray interpretation by Dr. Alexander and the medical reports of Drs. Green, Cohen, Naeye, Caffrey, and Oesterling were not considered in determining whether the Claimant was entitled to the irrebuttable presumption of death due to pneumoconiosis under § 718.304.

> When addressing the issue of invocation of the irrebuttable presumption pursuant to Section 718.304, the administrative law judge weighed only the opinions of Dr. Heidingsfelder, the autopsy prosector, and Dr. Wiot …. Dr. Alexander determined that the film dated July 18, 1999 was positive for complicated pneumoconiosis, Category A. Claimant's Exhibit 3. In addition, Drs. Green, Cohen, Naeye, Caffrey, Tuteur, Renn, Fino and Oesterling offered opinions, based upon a review of the medical evidence of record, as to whether the miner had complicated pneumoconiosis at the time of his death. Because the administrative law judge did not address all of the evidence relevant to the issue of whether the miner had complicated pneumoconiosis, we must vacate the administrative law judge's finding that claimant did not establish invocation of the irrebuttable presumption pursuant to Section 718.304….

Dugger, BRB No. 03-0434 BLA at 3-4.

The Board held that Dr. Heidingsfelder's correspondence with Mr. Marchand was not addressed in sequence, and the Board, therefore, vacated the finding that Dr. Heidingsfelder's opinion was equivocal. *Id.* at 5.

A split Board held that:

> When addressing th[e] issue [of complicated pneumoconiosis] on remand, the administrative law judge must first consider whether the presence of complicated pneumoconiosis has been established at Section 718.304(a) by x-ray evidence yielding one or more large opacities greater than one centimeter in diameter classified in Category A, B, or C. Dr. Alexander's interpretation of the x-ray dated July 19, 1999 must be included in the administrative

> law judge's weighing of the evidence relevant to Section 718.304(a). The administrative law judge must then determine whether the autopsy evidence yielded massive lesions in the lung under Section 718.304(b). When weighing Dr. Heidingsfelder's opinion under Section 718.304(b), the administrative law judge must determine whether Dr. Heidingsfelder's reports establish the existence of complicated pneumoconiosis in light of the sequence of his correspondence with the claims examiner.
>
> If a medical report contains diagnoses of conditions based on means other than x-rays or autopsy evidence, the administrative law judge must then consider, pursuant to Section 718.304(c), whether the physician has identified 'a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section.' … Regarding opinions like those of Drs. Green, Cohen, Naeye, Caffrey, Fino, Tuteur, and Oesterling, in which the physician does not use the term 'massive lesions,' the administrative law judge must determine whether the diagnosed condition would produce an opacity of larger than one centimeter in size if x-rayed…. Finally, if the administrative law judge finds that the existence of complicated pneumoconiosis has been established under Section 718.304(a), (b), or (c), he must then weigh all of the relevant evidence together to determine if claimant has established invocation of the irrebuttable presumption of death due to pneumoconiosis by a preponderance of the evidence.

Id. at 6-7.

The Board affirmed that the Death Certificate and Dr. Green's opinion did not support death due to pneumoconiosis under § 718.205(c). The Board stated that the review of Dr. Cohen's opinion was insufficient in that the undersigned did not identify the opinions relied upon to determine that the Miner's death was primarily due to metastatic cancer. *Id.* at 8. "In addition, the administrative law judge did not resolve the conflict between the determination of Drs. Green and Cohen that the Miner's lung cancer was in remission at the time of his death and contrary statements made by Drs. Renn, Repsher, Fino, Tuteur, Caffrey, Naeye, and Oesterling." *Id.*

Finally, under § 718.205(c), the Board held that the prior decisions did not address whether legal pneumoconiosis was a contributing cause of the miner's death.

> When addressing the issue of the existence of pneumoconiosis under Section 718.202(a), the administrative law judge considered only whether the miner suffered from clinical pneumoconiosis and did not weigh the evidence relevant to legal pneumoconiosis as defined in 20 C.F.R. § 718.201.[1] In addition, when discrediting Dr. Cohen's opinion, the administrative law judge did not determine whether the 'pulmonary condition' to which Dr. Cohen referred was legal pneumoconiosis and did not consider whether this condition caused, contributed to, or hastened the miner's death in accordance with Section 718.205(c) and the Seventh Circuit's decision in *Railey*.

BRB Slip op. at 9.

Findings of Fact and Conclusions of Law

The Findings of Fact and Conclusions of Law as stated in the original Decision and Order are adopted herein except to the extent they were found to be erroneous by the Benefits Review Board, or to the extent that they are inconsistent with the findings and conclusions made in this Decision and Order on Remand. The medical evidence as presented by the parties in the original claim is incorporated into this Decision and Order by reference.

Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. In order to receive benefits, the Claimant must prove that:

> The Miner had pneumoconiosis (*see* § 718.202);
>
> The Miner's pneumoconiosis arose out of coal mine employment (*see* § 718.203); and,
>
> The Miner's death was due to pneumoconiosis as provided by this section.

20 C.F.R. § 718.205(a).

[1] In analyzing the medical evidence for legal pneumoconiosis, the Board stated that the method used in calculating a smoking history was insufficiently explained and did not consider the opinions of Drs. Rao and Selby, both examining physicians. *Dugger*, BRB No. 03-0434 BLA at 9, n.7.

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. The Board affirmed that x-ray evidence supports a finding of pneumoconiosis under § 718.202(a)(1).

A finding of pneumoconiosis may be made on the basis of biopsy or autopsy results under § 718.202(a)(2). There is no biopsy evidence in the record. The Board affirmed that autopsy evidence supports a finding of pneumoconiosis under § 718.202(a)(2).

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. The presumption at § 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Under § 718.304, the existence of pneumoconiosis is established if the miner suffers from complicated pneumoconiosis. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the Administrative Law Judge must consider and weigh all relevant evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

Complicated Pneumoconiosis

Under § 718.304(a), complicated pneumoconiosis can be diagnosed when x-ray evidence yields one or more large opacities greater than one centimeter in diameter classified in Category A, B, or C.

In analyzing the evidence for complicated pneumoconiosis, the Board held that:

> Dr. Alexander's interpretation of the x-ray dated July 19, 1999 must be included in the administrative law judge's weighing of the evidence relevant to Section 718.304(a).

BRB Slip op. at 6, 7.

The record contains 32 interpretations of 25 x-rays. The only x-ray to be interpreted as positive for complicated pneumoconiosis is the July 18, 1999, x-ray film. Dr. Alexander, a Board-certified Radiologist and a B reader, interpreted the film as showing a large opacity measuring 15 mm (1.5 cm) in the

right upper zone indicating complicated pneumoconiosis, category A (CX 3). He noted that the "progressive upper lobe fibrosis" was new compared to prior x-rays.

Dr. Wiot disagreed with Dr. Alexander's interpretation of complicated pneumoconiosis. He opined that all x-rays reviewed and all CT scans interpreted showed simple coal workers' pneumoconiosis and did not show complicated pneumoconiosis. Dr. Wiot testified that Mr. Dugger's last coal mine exposure occurred in 1984. X-rays taken in 1998 showed pneumoconiosis with low profusion and no large opacities. The June 17, 1999 CT scan showed no large opacities. Given those facts, there is no way that a large opacity would be missed by the CT scan or that a large opacity could develop in a period of only 18 months. "That would never happen." (*See* EX 7).

Dr. Wiot, a Board-certified Radiologist and a B reader, further opined that the July 18, 1999, film relied upon by Dr. Alexander was unreadable (DX 33). Dr. Alexander rated the film as poor due to overexposed scapula and overlay. If a film quality is "poor" or "unreadable," then the study may be afforded little weight. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988).

Given the film quality problems noted by both physicians on the July 18, 1999, film, the overwhelming majority of negative films (24 films negative for complicated pneumoconiosis, 1 interpreted as positive), the overwhelming majority of negative interpretations for complicated pneumoconiosis (31 negative readings, 1 positive reading), and the well-reasoned testimony of Dr. Wiot that a large opacity of the type interpreted by Dr. Alexander simply could not form 15 years after the Miner's last exposure to coal dust, in such a short time span when all CT scans were negative for complicated pneumoconiosis, I find that x-ray evidence does not support a finding of complicated pneumoconiosis.

Under § 718.304(b), complicated pneumoconiosis can be found when diagnosed by biopsy or autopsy evidence showing massive lesions in the lung. In analyzing the autopsy evidence, the Board held that:

> When weighing Dr. Heidingsfelder's opinion under Section 718.304(b), the administrative law judge must determine whether Dr. Heidingsfelder's reports establish the existence of complicated pneumoconiosis in light of the sequence of his correspondence with the claims examiner.

BRB Slip op. at 6,7.

It is initially noted that the Claimant's Brief on Remand imperfectly states the objective criteria of complicated pneumoconiosis under § 718.304(b). The Claimant asserts that any autopsy finding "of lesions larger than one centimeter in diameter meets the objective criteria of complicated pneumoconiosis." (Claimant's Br. at 8-9).

As noted by the Board, "the administrative law judge must determine whether the diagnosed condition would produce an opacity of larger than one centimeter in size *if x-rayed*, as this is the objective measure of complicated pneumoconiosis set forth in the Act and the regulations." BRB slip op. at 6 (emphasis added); *see also, Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 243 (4th Cir. 1999) ("massive lesions, as described in [§ 718.304(b)], are lesions that when x-rayed, show as opacities greater than one centimeter in diameter"); *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 22 B.L.R. 2-93 (4th Cir. 2000); *Smith v. Island Creek Coal Co.*, 7 B.L.R. 1-734 (1985). A nodule diagnosed on autopsy can "only justify invocation of the presumption [in § 718.304(b)] if a physician provide[s] an opinion that such a nodule would produce an opacity of greater than one centimeter if viewed by X-ray…." *Riddle v. Director, OWCP*, 70 F.3d 1263 (4th Cir. 1995).

The Fourth Circuit offered further interpretation of § 718.304(b):

> The Pneumoconiosis Committee of the College of American Pathologists long ago set two centimeters as the minimum diameter for a lesion to constitute complicated pneumoconiosis. … The two centimeter standard recognizes the fact that nodules are generally larger on autopsy examination than they appear on a chest radiograph. … The statute, [however], does not mandate use of the medical definition of complicated pneumoconiosis. … 30 U.S.C. § 921(c)(3) requires that an equivalency determination be made.

Double B Mining, Inc., 177 F.3d at 244.

Dr. Heidingsfelder, a Forensic Pathologist, performed the Miner's autopsy. On macroscopic examination, he described the lungs as having one 3.5 cm lesion and several pulmonary anthracotic nodules, 0.4 cm to 2.0 cm. On microscopic examination, he noted multiple large nodules and lesions on many of the slides.

On August 22, 2000, Mr. Marchland wrote to Dr. Heidingsfelder stating, in part, "[y]our impression # 3 was focal massive pulmonary fibrosis, but I don't know if this equates to 'massive lesions' as defined in our regulations."

Dr. Heidingsfelder replied by letter dated September 21, 2000, and stated that "[i]n response to your question … my answer is 'yes. See Microscopic Report.'"

An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). A report is properly discredited where the physician does not explain how underlying documentation supports his diagnosis. *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982). Dr. Heidingsfelder's microscopic report finds lesions over 1.0 cm. He does not explain, however, how those microscopic lesion findings support a conclusion that the Miner suffered from lesions, which *if x-rayed*, would be greater than 1 cm. I find Dr. Heidingsfelder's simple "yes" answer, leaving the reader to interpret the significance of the microscopic report in relation to the regulations, to be inadequately supported, and I afford it less weight.

Dr. Green, a Board-certified Anatomic Pathologist, reviewed the autopsy slides and the autopsy reports, and found that the Miner had coal workers' pneumoconiosis which progressed to progressive massive fibrosis. He found "large dust-containing fibrotic masses measuring greater than 1 cm in diameter consistent with massive fibrosis. The three largest … measure 1.5 cm, 1.3 cm, and 1.4 cm." Dr. Green's opinion is well reasoned. He bases his opinion on the autopsy slides and report and opines that the largest opacities were over 1 cm in diameter and were consistent with "massive" fibrosis as defined in the regulations. Noting Dr. Green's superior credentials, I afford his opinion substantial weight.

Dr. Naeye, a Board-certified Pathologist, reviewed the autopsy reports and autopsy slides and found nodules between 1.0 and 1.5 cm in diameter. He opined that the larger opacities were the result of several smaller densities fusing and that

none of the larger nodules demonstrated the histologic characteristics of complicated pneumoconiosis. He supported his finding through review of x-ray evidence, which was consistently negative for complicated pneumoconiosis. He opined that the Miner did not suffer from complicated pneumoconiosis.

Dr. Naeye's opinion is well reasoned. He based his opinion on review of the autopsy slides, and explained why the larger opacities present did not display the characteristics of complicated coal workers' pneumoconiosis. He corroborated his findings with x-ray evidence that did not show large opacities over 1.0 cm. Noting Dr. Naeye's credentials, I afford his opinion substantial weight.

Dr. Caffrey, a Board-certified Pathologist, reviewed autopsy reports and 32 autopsy slides, and opined that the Miner suffers from severe simple coal workers' pneumoconiosis but does not suffer from complicated pneumoconiosis. He based his opinion on the fact that no lesion on any slide measured over 2 cm in diameter and that no lesions showed the typical microscopic appearance of complicated coal workers' pneumoconiosis. He explained the microscopic differences between complicated and simple coal workers' pneumoconiosis. He noted the large opacities seen by Dr. Heidingsfelder, but he disagreed with Dr. Heidingsfelder's interpretation.

Dr. Caffrey's opinion is well reasoned. He based his findings on review of the autopsy slides and opined that microscopic evaluation of the nodules was not supportive of complicated pneumoconiosis.

The Claimant argues that Dr. Caffrey's "insistence on a 2 centimeter standard for a diagnosis of complicated pneumoconiosis is contrary to law." Claimant's Br. at 9. The Fourth Circuit's decision in *Double B Mining, Inc.*, notes the 2 centimeter standard for autopsy lesions and holds that the statute does not mandate use of the medical definition of complicated pneumoconiosis. In no way, however, does it *preclude* reliance on that standard by a physician. I find Dr. Caffrey's opinion to be based on objective evidence and well reasoned. Noting Dr. Caffrey's superior credentials, I afford his opinion substantial weight.

Dr. Oesterling, a Board-certified Anatomical and Clinical Pathologist, reviewed autopsy records and the autopsy slides and opined that there were multiple lesions measuring 1.4 to 1.8 cm, and that none achieved the dimensions required for a diagnosis of progressive massive fibrosis. He noted that several smaller nodules were coalescing, "however, they do not demonstrate the

usual dense fibrous tissue associated with progressive massive fibrosis, nor do they show the usual central necrosis."

Dr. Oesterling's opinion is well reasoned. He based his opinion on review of the autopsy slides and supported his diagnosis with explanation of how microscopic review of individual slides supported his diagnosis. Noting Dr. Oesterling's credentials, I afford his opinion substantial weight.

In review of the autopsy evidence, I give more weight to the combined well-reasoned opinions of Drs. Oesterling, Caffrey, and Naeye over the reasoned opinion of Dr. Green. Dr. Heidingsfelder's opinion was unreasoned. All physicians saw the same opacities and documented similar sizes and quantities of nodules. A majority of the reviewing physicians with superior credentials found that the nodules observed did not represent complicated pneumoconiosis as defined in the regulations. This finding is bolstered by the fact that x-ray and CT scan evidence do not show an opacity measuring over 1 cm on any film or CT scan of record. The existence of complicated pneumoconiosis is not established by autopsy evidence under § 718.304(b).

Under § 718.304(c), complicated pneumoconiosis may be found where a physician has identified "a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section." 20 C.F.R. § 718.304(c), *Ziegler Coal Co. v. Director, OWCP [Hawker],* 326 F.3d 894 (7th Cir. 2003).

The Board held that:

> Regarding opinions like those of Drs. Green, Cohen, Naeye, Caffrey, Fino, Tutuer and Oesterling in which the physician does not use the term "massive lesions," the administrative law judge must determine whether the diagnosed condition would produce an opacity of larger than one centimeter in size if x-rayed….

BRB, slip op. at 6.

I have reviewed the opinions of the Pathologists of record, Drs. Green, Naeye, Caffrey, and Oesterling.

Treatment records from Good Samaritan Hospital offer no further support. On June 23, 1999, Dr. Oza noted COPD with multiple blebs on chest x-ray, but did not provide any size of the blebs seen, and he diagnosed only extensive small cell lung

cancer. On June 9, 1999, Dr. Clark interpreted a chest x-ray that "probably" showed interstitial disease, but opined that it was difficult to make a proper determination "until the current [congestive heart failure] has cleared."

Dr. Cohen, a Board-certified Internist, Pulmonologist, and B reader, diagnosed simple and complicated pneumoconiosis. He based his diagnosis of complicated pneumoconiosis on the autopsy reports of Drs. Heidingsfelder and Green. It is reasonable to assign greater weight to the opinion of the physician who performs the autopsy [or reviews the slides] over the opinions of others who review his findings without reviewing the slides. *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). Dr. Cohen expresses his disagreement with the opinions of Drs. Naeye and Caffrey, reflecting the view that the larger opacities seen at autopsy would have met the regulatory definition of complicated pneumoconiosis.

Dr. Cohen is not a Pathologist, but a Pulmonologist. Dr. Cohen did not review the slides himself, but rather formed his opinion by reading and evaluating the opinions of the Pathologists. He found the interpretations of the autopsy reports of Drs. Heidingsfelder and Green to be more persuasive and, therefore, adopted their viewpoint. While Dr. Cohen's report is reasoned and based on objective data collected by other physicians, I note that his expertise is not in the field of Pathology. I afford his opinion some weight.

Dr. Repsher, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and B reader, opined that the x-rays, CT scans, and autopsy reports showed only simple coal workers' pneumoconiosis. Dr. Repsher's report is well reasoned and based on objective data collected by other physicians. He evaluated the autopsy materials, and found that x-rays and CT scans did not support a finding of complicated pneumoconiosis. Noting that Dr. Repsher is not a Board-certified Pathologist or Radiologist, I afford his opinion some weight.

Dr. Fino, a Board-certified Internist and Pulmonologist, reviewed x-rays, CT scans, and autopsy reports and opined that the Miner suffered from only simple coal workers' pneumoconiosis. Dr. Fino's report is well reasoned and based on objective data collected by other physicians. He evaluated the autopsy materials, and found that x-rays and CT scans did not support a finding of complicated pneumoconiosis. Noting that Dr. Fino is not a Board-certified Pathologist or Radiologist, I afford his opinion some weight.

Dr. Renn, a Board-certified Internist, Pulmonologist, and B reader, reviewed x-rays, CT scans, and autopsy reports and opined that the Miner suffered from only simple coal workers' pneumoconiosis. Dr. Renn's report is well reasoned and based on objective data collected by other physicians. He evaluated the autopsy materials, and found that x-rays and CT scans did not support a finding of complicated pneumoconiosis. Noting that Dr. Renn is not a Board-certified Pathologist or Radiologist, I afford his opinion some weight.

Dr. Tuteur, a Board-certified Internist, Pulmonologist, and B reader, reviewed x-rays, CT scans, and autopsy reports and opined that the Miner suffered from only simple coal workers' pneumoconiosis. Dr. Tuteur's report is well reasoned and based on objective data collected by other physicians. He evaluated the autopsy materials, and found that x-rays and CT scans did not support a finding of complicated pneumoconiosis. Noting that Dr. Tuteur is not a Board-certified Pathologist or Radiologist, I afford his opinion some weight.

The evidence does not support the invocation of the irrebuttable presumption under § 718.304. X-ray evidence is overwhelmingly negative for complicated pneumoconiosis. This was corroborated by negative CT scans. The well-reasoned opinions of Drs. Oesterling, Caffrey, and Naeye, all Board-certified Pathologists, stated that autopsy evidence did not support a finding that the lesions seen on autopsy would have been viewed as over 1 cm in diameter if x-rayed. There were six x-rays taken of the Claimant during the last two months of his life. These opinions are supported by the fact that all of the final six x-rays were negative for complicated pneumoconiosis.

The medical opinions of Drs. Repsher, Fino, Renn, and Tuteur support the finding of no complicated pneumoconiosis. I find that complicated pneumoconiosis is not established under § 718.202(a)(3).

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

The Board affirmed the finding that clinical pneumoconiosis was established under § 718.202(a)(4). The Board held, however,

that the issue of legal pneumoconiosis was not adequately resolved.

> When addressing the issue of the existence of pneumoconiosis under Section 718.202(a), the administrative law judge considered only whether the miner suffered from clinical pneumoconiosis and did not weigh the evidence relevant to legal pneumoconiosis as defined in 20 C.F.R. § 718.201. In addition, when discrediting Dr. Cohen's opinion, the administrative law judge did not determine whether the "pulmonary condition" to which Dr. Cohen referred was legal pneumoconiosis….

BRB slip op. at 9.

I review the opinions of record, therefore, on the issue of legal pneumoconiosis under § 718.202(a)(4).

Treatment notes from Good Samaritan Hospital primarily discuss the Miner's lung cancer. In a May 6, 1998 History and Physical, Dr. Hall diagnosed "mixed lung disease" but failed to explain what that means or how he reached that diagnosis. On April 17, 1998, Dr. Hall noted severe COPD but did not list an etiology.

Dr. Cohen opined that the miner's "pulmonary condition" was simple coal workers' pneumoconiosis, as demonstrated by physical examinations, pulmonary function testing and x-ray evidence. Dr. Cohen made no finding consistent with legal pneumoconiosis.

Dr. Oesterling noted the Miner's cancer, simple coal workers' pneumoconiosis and bronchopneumonia and opined that the Miner's lifetime symptoms were attributable to the Miner's severe emphysema, including marked bullous emphysema, secondary to a significant smoking history. No diagnosis compatible with legal pneumoconiosis was made.

Dr. Green opined that the Miner's substantial smoking history (70 pack years) and significant coal dust exposure (40 years) contributed to the emphysema shown at autopsy. Such a diagnosis, if reasoned, would meet the definition of legal pneumoconiosis. Dr. Green's opinion, however, is not well reasoned. Although Dr. Green reviewed the autopsy slides, he failed to explain the basis for his finding that both smoking and coal dust contributed to the Miner's emphysema. There was no explanation or documentation of his dual causation diagnosis. As such, it is an unsupported conclusion and not a reasoned opinion finding legal pneumoconiosis.

Dr. Repsher diagnosed mild COPD with severe bullous emphysema of the apices, of no clinical significance, demonstrated by pulmonary function testing. Dr. Repsher did not connect the COPD or emphysema to coal dust exposure. As such, Dr. Repsher's opinion does not support a finding of legal pneumoconiosis.

Dr. Fino diagnosed simple coal workers' pneumoconiosis, heart failure, and lung cancer. No pulmonary condition which could be construed as a form of legal pneumoconiosis was diagnosed.

Dr. Renn diagnosed tobacco smoke-induced pulmonary emphysema, but did not list the basis of his diagnosis. His finding, as written, does not support legal pneumoconiosis, and as he lists no basis for his smoking etiology, his emphysema etiology is not well reasoned.

Dr. Tuteur focused the majority of his opinion on the cause of death, and he made no diagnosis that could be construed as a form of legal pneumoconiosis.

Dr. Caffrey opined that Mr. Dugger's carcinoma of the lung and his severe COPD were caused by his years of smoking cigarettes. Neither diagnosis supports a legal pneumoconiosis finding.

Dr. Naeye opined that the Miner's 60-80 pack year history of cigarette smoking was the major cause of his emphysema, cardiac arrhythmias, and failure. He did not list a secondary cause. His opinion offers no support for a legal pneumoconiosis finding.

The Miner's Death Certificate lists no ailment consistent with legal pneumoconiosis.

Dr. Heidingsfelder noted localized emphysema, pulmonary emphysema, and emphysematous blebs and bullae but did not list an etiology. The diagnoses made are not tied to coal dust exposure and provide no link to a possible legal pneumoconiosis diagnosis.

Taken as a whole, the record contains no evidence supporting legal pneumoconiosis as defined in the regulations.

Death Due to Pneumoconiosis

Under § 718.205(c), a claimant may establish death due to pneumoconiosis in any of the following circumstances: (1) where competent medical evidence establishes that the miner's death was due to pneumoconiosis; (2) where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis; or, (3) where the presumptions set forth at § 718.304 is applicable. As held above, the presumptions of § 718.304 are not applicable to this claim. Under the Seventh Circuit, any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205. *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992).

The Board stated that:

> On remand, if the administrative law judge does not find that claimant is entitled to the irrebuttable presumption of death due to pneumoconiosis set forth in Section 718.304, he must reconsider whether claimant has met her burden of proof under Section 718.205(c) with respect to either clinical or legal pneumoconiosis. The administrative law judge must consider, therefore, the medical opinions in which the physicians discuss whether the miner's chronic obstructive lung disease is related to dust exposure in coal mine employment or cigarette smoking or a combination of the two and must resolve the conflict in these opinions. … In rendering his findings, the administrative law judge must identify the evidence he has considered, set forth his conclusions regarding the probative weight to which the evidence is entitled, and provide the rationale underlying these conclusions.

BRB Slip op. at 9.

I found above that the Claimant is not entitled to the irrebuttable presumption in § 718.304 and that the Miner did not suffer from legal pneumoconiosis as defined in the regulations. The Board affirmed that the Death Certificate and Dr. Green's opinion do not support death due to pneumoconiosis pursuant to § 718.205(c). BRB Slip op. at 8. The remainder of the evidence will be reviewed to determine whether the Miner's death was due to pneumoconiosis under § 718.205(c).

Dr. Cohen opined that coal dust exposure "was a primary cause or contribution to the development of [the Miner's] severe diffusion impairment and simple and advanced pneumoconiosis which significantly contributed to his respiratory death." Dr. Cohen's report is not well reasoned. He does not incorporate the Miner's extensive smoking history into his cause of death analysis. He fails to discuss the Miner's normal arterial blood gas readings.

Dr. Cohen notes a "minimal obstructive lung defect" on pulmonary function studies from 1987 with mild decrease in diffusing capacity which could be "due to poor test performance." He fails to address his own quality concerns regarding the validity of the 1987 testing. Later, he opines that the Miner had "*severe diffusion impairment* in 1987, a sign of substantial and clinically significant interstitial lung disease."

Dr. Cohen is inconsistent in his own report. On the January 13, 1987, pulmonary function study he finds a mild decrease in diffusing capacity possibly due to poor effort, creating the possibility of a nonconforming, invalid reading. He later characterizes the same study as showing severe diffusion impairment without reference to the validity of the study or his previous determination that the results showed only a "mild" defect. A report may be given little weight where it is internally inconsistent and inadequately reasoned. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1(1999) (*en banc* on recon.).

It is also proper for the Administrative Law Judge to accord less weight to a physician's opinion that is based on premises contrary to the Judge's findings. *Furgerson v. Jericol Mining, Inc.* 22 B.L.R. 1-216 (2002) (*en banc*); *Amax Coal Co. v. Director, OWCP [Chubb]*, 312 F.3d 882 (7th Cir. 2002). Dr. Cohen bases his cause of death analysis in part on his diagnosis that the Miner suffers from complicated pneumoconiosis. The evidence does not support such a finding. Noting the many deficiencies in Dr. Cohen's report, I afford it less weight.

Dr. Oesterling, a Board-certified Anatomical and Clinical Pathologist, opined that the Miner's coal workers' pneumoconiosis was insufficient to have in any way contributed to, hastened, or caused the Miner's death. He opined that the Miner, weakened by radiation and chemotherapy, suffered from cancer and pulmonary congestion due to a failing left ventricle. The cancer and pulmonary congestion caused bronchopneumonia and pulmonary abscess formation which, in turn, caused the Miner's death. He opined that neither of these conditions was related

to coal dust exposure. Dr. Oesterling's opinion is well reasoned. He based his opinion on personal review of the autopsy slides and upon the medical history of the Miner. He documented the evidence supporting his findings. Noting Dr. Oesterling's superior credentials, I afford his opinion substantial weight.

Dr. Repsher, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and B reader, opined that the Miner's death was not caused by, contributed to, or hastened by his work as a coal miner or from clinically significant coal workers' pneumoconiosis. Dr. Repsher opined that the Miner suffered from extremely severe coronary artery disease and small cell cancer, either of which was capable of being the sole cause of death. He opined that the Miner's coal workers' pneumoconiosis, mild COPD, and his emphysema did not contribute to his death because the Miner had no pulmonary function test abnormalities.

Dr. Repsher's opinion is well reasoned but based on very old pulmonary function testing. He opined that the Miner showed no pulmonary abnormalities, but the most recent testing reviewed was from 1987, nearly 12 years before the Miner died. The autopsy reports and later medical examinations confirmed many cardiac and cancer-related ailments, but there was no current pulmonary evaluation included to support or weigh against a pulmonary contribution to cause of death. As Dr. Repsher based his opinion in great part on data collected a dozen years before the Miner died, I afford his opinion some weight.

Dr. Fino, a Board-certified Internist, Pulmonologist, and B reader, opined that the Miner died due to lung cancer and thrombophlebitis, a clot in the leg, which is often a terminal factor in lung cancer. Dr. Fino noted that the cancer had spread to the spine and the brain. He opined that the Miner would have died as and when he did had he never stepped foot in the mines, and that coal dust inhalation neither caused, nor contributed to, nor hastened the Miner's death. Dr. Fino's report is well reasoned. He supports his view with autopsy and hospitalization records. He opined that pulmonary function and arterial blood gases (over a period of 1984-1999) did not show pulmonary or respiratory disability. Noting Dr. Fino's superior credentials, I afford his opinion substantial weight.

Dr. Renn, a Board-certified Internist, Pulmonologist, and B reader, opined that the Miner died due to "terminal bronchopneumonia with abscess formation owing to progressive inanition from small cell carcinoma of the lung metastatic to his brain, tobacco smoke-induced pulmonary emphysema, and immune suppression as a result of chemotherapy and radiation therapy."

In his opinion, the Miner's death was neither caused, nor contributed to, by his exposure to coal dust and his simple coal workers' pneumoconiosis. Dr. Renn's report is well reasoned. He based his findings on an extensive review of all medical evidence including autopsy materials, and opined that the Miner's lung function test in 1987, calculated with the progression shown in the records of his pulmonary emphysema, showed that the coal workers' pneumoconiosis had no causation or effect on the cancer or the terminal bronchopneumonia. Noting Dr. Renn's superior credentials, I afford his opinion substantial weight.

Dr. Tuteur, a Board-certified Internist and Pulmonologist, opined that the Miner "died with and because of severe progressive coronary artery disease treated both with surgical and medical management further aggravated by the primary cause of death, small cell carcinoma of the lung metastatic to brain" and associated bronchopneumonia. Dr. Tuteur's report is well reasoned. He based his opinion on the objective medical evidence including pulmonary function tests, arterial blood gases, autopsy reports and hospitalization records from the Miner's final illness. Noting Dr. Tuteur's superior credentials, I afford his opinion substantial weight.

Dr. Caffrey opined that pneumoconiosis did not cause, contribute to, or hasten the Miner's death. He opined that the medical evidence, including autopsy slides and hospitalization records, shows that the Miner died due to carcinoma of the lung, which metastasized to his brain, and possibly other organs.

Dr. Caffrey's opinion is reasoned, but based on limited information. While he viewed the autopsy slides and read the pathology reports of record, he did not have access to the pulmonary data and physical examination reports of the other physicians. Greater weight may be accorded that opinion which is supported by more extensive documentation over the opinion which is supported by limited medical data. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984). I find Dr. Caffrey's opinion to be reasoned and based on objective evidence. I afford his opinion some weight.

Dr. Naeye opined that coal workers' pneumoconiosis did not hasten the Miner's death. He opined that a combination of chronic congestive heart failure and cancer were responsible for Mr. Dugger's death. He did not list the basis for his opinion. An unsupported conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984); *Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985). I find Dr. Naeye's

cause of death findings unreasoned and I afford them less weight.

Dr. Heidingsfelder, a Forensic Pathologist and the autopsy prosector, noted many findings but did not diagnose a cause of death. An opinion which is silent as to a particular issue is not probative of that issue. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). I afford no probative weight to Dr. Heidingsfelder's opinion on the issue of death due to pneumoconiosis.

Taken as a whole, most physicians of record agree that the Miner suffered from simple coal workers' pneumoconiosis and that the Miner had significant cardiac problems and lung cancer, which resulted in bronchopneumonia and finally death. The well-reasoned opinions of Drs. Oesterling, Fino, Renn, and Tuteur opine that the Miner's simple coal workers' pneumoconiosis did not hasten the Miner's death. This diagnosis is corroborated by the opinions of Drs. Repsher and Caffrey. The opinions of Drs. Green, Cohen, and Naeye are not well reasoned. I find that the Claimant has not established that the Miner's death was due to pneumoconiosis as defined in § 718.205(c).

Entitlement

Susan M. Dugger, the Claimant, has not established entitlement to benefits under the Act.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

It is, therefore,

ORDERED that the claim of Susan M. Dugger for benefits under the Act is hereby DENIED.

A

Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.